Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FOUNDATION SURGICAL HOSPITAL
5410 WEST LOOP S STE 3600
BELLAIRE TX 77401-2103

Respondent Name
Hartford Underwriters Insurance

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-12-1246-01

MFDR Date Received
December 22, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DND FOR TC Modifier & or License. We only take picture. No Reading was Done."

Amount in Dispute: $1067.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per Medicare Radiology furnished to hospital outpatient are paid under OPPS. Services not billed correctly."

Response Submitted by: The Hartford, 300 S. State St. Syracuse, NY 13202

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 16, 2011	Outpatient Hospital Services	$1,067.20	$1,060.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.20 sets out medical bill submission requirements for health care providers.
3. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 11, 2011
   - W1 – WORKERS COMPENSATION SATE FEE SCHEDULE ADJUSTMENT. PAYMENT OF SERVICES

ARE INCLUDED IN THE VISIT RATE.
- 4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING. THE MODIFIER USED FOR RE-PRICING IS MISSING OR INVALID

Explanation of benefits dated November 28, 2011
- W1 – WORKERS COMPENSATION SATE FEE SCHEDULE ADJUSTMENT. PAYMENT OF SERVICES ARE INCLUDED IN THE VISIT RATE.
- 4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING. THE MODIFIER USED FOR RE-PRICING IS MISSING OR INVALID.

Issues

1. Did the requestor submit the medical bill in compliance with Division and CMS rules?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Disputed services were denied with the following reason code, "4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING. THE MODIFIER USED FOR RE-PRICING IS MISSING OR INVALID." 28 Texas Administrative Code §134.20(b) (1) states in pertinent part, "for coding, billing, reporting and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing …and other payment policies in effect on the date a service is provided…" Review of the documentation finds the requestor submitted a claim for code 72158 with the TC modifier. Both the code and modifier are valid per Current Procedural Terminology (CPT) coding instructions therefore; Carrier's denial is not supported. Reimbursement for the disputed services will be calculated as follows.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 72158 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0337, which, per OPPS Addendum A, has a payment rate of $533.60. This amount multiplied by 60% yields an unadjusted labor-related amount of $320.16. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $317.02. The non-labor related portion is 40% of the APC rate or $213.44. The sum of the labor and non-labor related amounts is $530.46. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $530.46. This amount multiplied by 200% yields a MAR of $1,060.92.
4. The total allowable reimbursement for the services in dispute is $1,060.92. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $1,060.92. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,060.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,060.92, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		May 9, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.